		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021014

Facility Name: PLEASANT HILL VILLAGE

Address: 1010 WEST NORTH (Number) GIRARD (City) 62640 (Zip Code)

County: MACOUPIN

Telephone Number: (217) 627-2181 **Fax #** (217) 627-3604

IDPA ID Number: 37-0330985001

Date of Initial License for Current Owners: 03/07/76

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: PAULETTE BUCH-MILLER **Telephone Number:** (217)627-2181

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) PAULETTE BUCH-MILLER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) SEE ATTACHED COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,179	16,781		33,960	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,179	16,781		33,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.94%

D. How many bed-hold days during this year were paid by Public Aid?
300 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/03 Fiscal Year: 6/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	171,539	14,493	4,608	190,640		190,640		190,640			1
2	Food Purchase		153,607		153,607		153,607	(359)	153,248			2
3	Housekeeping	60,804	6,448		67,252		67,252		67,252			3
4	Laundry	50,724	11,102		61,826		61,826		61,826			4
5	Heat and Other Utilities			91,078	91,078	(757)	90,321		90,321			5
6	Maintenance	39,209	3,737	13,499	56,445		56,445		56,445			6
7	Other (specify):*											7
8	**TOTAL General Services**	322,276	189,387	109,185	620,848	(757)	620,091	(359)	619,732			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,091,331	37,503	78,553	1,207,387		1,207,387		1,207,387			10
10a	Therapy			2,585	2,585		2,585		2,585			10a
11	Activities	64,711	2,919	4,887	72,517		72,517		72,517			11
12	Social Services	30,127	1,377		31,504		31,504		31,504			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* CHAPLIN	26,448			26,448		26,448		26,448			15
16	**TOTAL Health Care and Programs**	1,212,617	41,799	92,025	1,346,441		1,346,441		1,346,441			16
	C. General Administration											
17	Administrative	112,383			112,383		112,383		112,383			17
18	Directors Fees											18
19	Professional Services			43,715	43,715		43,715		43,715			19
20	Dues, Fees, Subscriptions & Promotions			21,140	21,140		21,140	(11,455)	9,685			20
21	Clerical & General Office Expenses	22,197	9,061	10,544	41,802		41,802	(3,604)	38,198			21
22	Employee Benefits & Payroll Taxes			189,611	189,611		189,611		189,611			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,144	7,144		7,144		7,144			24
25	Other Admin. Staff Transportation			1,153	1,153		1,153		1,153			25
26	Insurance-Prop.Liab.Malpractice			82,162	82,162		82,162		82,162			26
27	Other (specify):* CAPTIVE STUDY			10,000	10,000		10,000		10,000			27
28	**TOTAL General Administration**	134,580	9,061	365,469	509,110		509,110	(15,059)	494,051			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,669,473	240,247	566,679	2,476,399	(757)	2,475,642	(15,418)	2,460,224			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PLEASANT HILL VILLAGE #0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			100,947	100,947		100,947		100,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,111	39,111		39,111	(10,741)	28,370			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			660	660		660		660			34
35	Rent-Equipment & Vehicles			4,164	4,164		4,164		4,164			35
36	Other (specify):* FARM EXPENSE			2,186	2,186		2,186	(2,186)				36
37	**TOTAL Ownership**			147,068	147,068		147,068	(12,927)	134,141			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					757	757		757			40
41	Coffee and Gift Shops			11,250	11,250		11,250		11,250			41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			64,905	64,905	757	65,662		65,662			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,669,473	240,247	778,652	2,688,372		2,688,372	(28,345)	2,660,027			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(359)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,004)	21		5
6	Rented Facility Space	(1,600)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,741)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,472)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,983)	20		28
29	Other-Attach Schedule FARMLAND EXPENSE	(2,186)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,345)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,345)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		(757)	5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ (757)		47

PLEASANT HILL VILLAGE

ID# 0021014

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(359)	0	0	0	0	0	0	0	0	0	0	(359)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(359)	0	0	0	0	0	0	0	0	0	0	(359)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,455)	0	0	0	0	0	0	0	0	0	0	(11,455)	20
21	Clerical & General Office Expenses	(3,604)	0	0	0	0	0	0	0	0	0	0	(3,604)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(15,059)	0	0	0	0	0	0	0	0	0	0	(15,059)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,418)	0	0	0	0	0	0	0	0	0	0	(15,418)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,741)	0	0	0	0	0	0	0	0	0	0	(10,741)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,741)	0	0	0	0	0	0	0	0	0	0	(10,741)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,159)	0	0	0	0	0	0	0	0	0	0	(26,159)	45

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		PLEASANT HILL RESIDENCE	GIRARD	INDEPENDENT LIVING CENTER

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CITY OF GIRARD BOND B		X	REFINANCE FACILITY CON	$5,070.00	12/7/00	$ 669,084	$ 596,332	12/15/16	0.0500	$ 30,587	1
2	CITY OF GIRARD BOND C		X	REFINANCE DEMENTIA WI	$2,353.00	12/7/00	76,192	13,832	12/15/03	0.0700	1,975	2
3	FIRST NATIONAL BANK		X	PURCHASE BUS	$541.00	4/8/03	27,588	26,859	4/15/08	0.0650	352	3
4												4
5												5
	Working Capital											
6	FIRST NATIONAL BANK		X	OPERATING LINE OF CREDIT		1/27/03	167,000			0.0675	3,039	6
7	VARIOUS VENDORS		X	OPERATING SUPPLIES							3,158	7
8												8
9	TOTAL Facility Related				$7,964.00		$ 939,864	$ 637,023			$ 39,111	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 939,864	$ 637,023			$ 39,111	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT HILL VILLAGE COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0021014

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior BRICK Frame STEEL & FIRE RESIS Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 29,505
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred: 1973-1976

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	243,065	1905-1975*	$ 28,500	1
2					2
3	TOTALS	243,065		$ 28,500	3

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1976	1976	$ 975,998	$ 24,400	40	$ 24,400	$	$ 666,932	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING, PA SYSTEM, PHV SIGN, DIRECTORY BOARD			1976	5,916						9
10	DIRECTORY BOARD LETTERS, PAITO CEMENT, LANDSCAPING			1977	1,273						10
11	LANDSCAPING, AIR CONDITIONER, FLAG POLE LIGHT			1978	6,194						11
12	LANDSCAPING, FENCE, CABINETS, INTERCOM, & MIKE MIXER			1980	3,688						12
13	REMODELING			1981	485						13
14	ENERGY CONTROL SYSTEM, REMODELING			1982	19,060						14
15	CABINETS			1983	271						15
16	CABINET TOP			1984	408						16
17	GARAGE SHOP, STORAGE BLDG, REMODELING, DRIVEWAY			1985	74,072						17
18	REMODELING			1986	5,469						18
19	BACKFLOW PREVENTOR, WINDOW & MIXING VALVE			1989	8,180						19
20	FIRE ALARM			1991	1,298						20
21	NEW ROOF, STORM WINDOWS, PAVILION			1992	61,405	40,351		40,351		354,367	21
22	LANDSCAPING			1993	1,240						22
23	LANDSCAPING, ROOF			1993	43,344						23
24	NEW ROOF, REMODELING, AIR CONDITIONERS			1994	32,226						24
25	SECURITY SYSTEM, REMODELING			1994	6,907						25
26	ARCHITECH, REMODELING, A/C, CARPET, FLOOR, PAINT & PAP			1995	40,250						26
27	DRIVEWAY, ARICHITECH, LANDSCAPING, A/C WINDOW TREAT			1995	28,013						27
28	ROOF, WATERLINE, COVEBASE & HAND RAIL			1996	40,657						28
29	LANDSCAPING			1997	915						29
30	ROOF TOP AIR CONDITIONER			1997	6,795						30
31	PAINT & WALL PAPER			1997	24,720						31
32	FLOORING			1997	12,182						32
33	COVEBASE			1997	2,713						33
34	REPLACE CEILING			1997	16,220						34
35	EXHAUST FAN			1997	428						35
36	WATER HYDRANT			1997	527						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING AREA	1998	$ 17,920	$		$	$	$	37
38	LANDSCAPING	1998	715						38
39	ARCHITECH FEES	1998	8,912						39
40	PAINT & WALL PAPER	1998	4,691						40
41	FLOORING	1998	428						41
42	WALL TREATMENTS & PICTURES	1998	442						42
43	WINDOWS	1998	2,123						43
44	OUTDOOR LIGHTING	1998	2,761						44
45	FIRE ALARM SYSTEM	1998	3,218						45
46	HEATING & COOLING SYSTEM	1998	1,824						46
47	LANDSCAPING	1999	1,439						47
48	DEMENTIA WING	1999	287,249						48
49	DEMENTIA WING ELECTRICAL	1999	589						49
50	DEMENTIA WING SURVEY	1999	3,250						50
51	PAINT & WALL PAPER	1999	4,025						51
52	WINDOW TREATMENT	1999	526						52
53	CARPET	1999	2,531						53
54	HEATING & COOLING SYSTEM	1999	4,384						54
55	ROOF TOP AIR CONDITIONER	1999	6,940						55
56	LANDSCAPING	2000	1,600						56
57	DEMENTIA WING	2000	19,566						57
58	SURVEY INDEPENDENT LIVING CENTER	2000	1,875						58
59	SECURITY DOOR ALARM	2000	1,415						59
60	HOT WATER HEATING SYSTEM	2000	26,436						60
61	CARPET	2000	4,462						61
62	VINAL SLIDING DOOR	2000	2,359						62
63	HEATING & COOLING SYSTEM	2000	6,368						63
64	LANDSCAPING	2001	1,600						64
65	ELECTRICAL WORK	2001	850						65
66	MASTER PLAN	2001	10,000						66
67	NEW LAUNDRY ROOM WALL	2001	497						67
68	DUCT WORK	2001	344						68
69	WATER LINE	2001	60,000						69
70	TOTAL (lines 4 thru 69)		$ 1,912,193	$ 64,751		$ 64,751	$	$ 1,021,299	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,912,193	$ 64,751		$ 64,751	$	$ 1,021,299	1
2	SLIDER WINDOWS	2001	2,469						2
3	FLOORING	2001	2,364						3
4	PAINT	2001	475						4
5	FIRE ALARM SYSTEM	2001	3,317						5
6	INTERIOR DECORATING	2001	1,863						6
7	ELECTRIC HEAT UNITS	2001	7,940						7
8	DRIVEWAY	2002	21,209						8
9	SIDEWALK	2002	960						9
10	DOORS	2002	2,515						10
11	AC CONDENCER	2002	1,572						11
12	WINDOWS	2002	266						12
13	EXHAUST FAN	2002	1,802						13
14	COUNTER TOP & WALL REPAIR	2002	604						14
15	ELECTRICAL GROUNDING	2002	2,581						15
16	POLE LIGHT	2002	3,337						16
17	ELECTRIC HEAT	2002	704						17
18	ENTRYWAY CULVERT	2003	2,600						18
19	700' 6" TILE	2003	1,561						19
20	CONCRETE WASHER BASE	2003	750						20
21	PERGOLA	2003	2,800						21
22	MASTER PLAN DEVELOPMENT	2003	892						22
23	HEATER	2003	1,064						23
24	SIGN LIGHTING	2003	2,529						24
25	CARPET	2003	378						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,978,745	$ 64,751		$ 64,751	$	$ 1,021,299	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 295,147	$ 31,417	$ 31,417	$	VARIOUS	$ 154,585	71
72	Current Year Purchases	19,466	1,767	1,767		VARIOUS	1,767	72
73	Fully Depreciated Assets	251,977				VARIOUS	251,977	73
74								74
75	TOTALS	$ 566,590	$ 33,184	$ 33,184	$		$ 408,329	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HOME UPKEEP	1993 CHEVY VAN	1994	$ 11,600	$	$	$	5	$ 11,600	76
77	HOME UPKEEP	PICKUP W/BLADE	2003	2,001	133	133		5	133	77
78	RESIDENT OUTINGS	BUS	2003	57,588	2,879	2,879		5	2,879	78
79										79
80	TOTALS			$ 71,189	$ 3,012	$ 3,012	$		$ 14,612	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,645,024	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 100,947	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 100,947	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,444,240	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,164 Description: OFFICE COPIER
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

AIDES WERE ALREADY TRAINED

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 238,799	$	1
2	Cash-Patient Deposits	2,550		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,679)	115,142		3
4	Supply Inventory (priced at COST)	10,377		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,303		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 385,171	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	28,500		13
14	Buildings, at Historical Cost	1,896,634		14
15	Leasehold Improvements, at Historical Cost	82,616		15
16	Equipment, at Historical Cost	637,274		16
17	Accumulated Depreciation (book methods)	(1,444,240)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,505		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,763)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CASH RESERVE	62,000		22
23	Other(specify): LAND	60,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,338,526	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,723,697	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,901	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,550		28
29	Short-Term Notes Payable	45,570		29
30	Accrued Salaries Payable	45,647		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,102		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,316		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 142,086	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,859		39
40	Mortgage Payable			40
41	Bonds Payable	564,594		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 591,453	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 733,539	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 990,158	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,723,697	$	48

***(See instructions.)**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 985,825	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 985,825	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,333	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,333	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 990,158	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,609,005	1
2	Discounts and Allowances for all Levels	(2,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,606,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	15,803	12
13	Barber and Beauty Care	757	13
14	Non-Patient Meals	359	14
15	Telephone, Television and Radio	2,004	15
16	Rental of Facility Space	1,600	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,523	23
	D. Non-Operating Revenue		
24	Contributions	19,709	24
25	Interest and Other Investment Income***	10,741	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,450	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	FARM INC. 3664 FUND RAISING 30000	33,664	28
28a	TRANSFER FROM ENDOWMENT FUND	1,703	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,367	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,692,705	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	620,848	31
32	Health Care	1,346,441	32
33	General Administration	509,110	33
	B. Capital Expense		
34	Ownership	147,068	34
	C. Ancillary Expense		
35	Special Cost Centers	11,250	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,688,372	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,333	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,333	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,080	$ 43,908	$ 21.11	1
2	Assistant Director of Nursing	1,832	2,080	40,058	19.26	2
3	Registered Nurses	3,036	3,092	60,429	19.54	3
4	Licensed Practical Nurses	16,385	17,343	263,217	15.18	4
5	Nurse Aides & Orderlies	66,885	70,635	664,448	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,637	1,753	16,071	9.17	9
10	Activity Assistants	7,016	7,179	48,640	6.78	10
11	Social Service Workers	3,358	3,587	30,127	8.40	11
12	Dietician					12
13	Food Service Supervisor	1,826	1,961	15,543	7.93	13
14	Head Cook	3,588	3,950	31,721	8.03	14
15	Cook Helpers/Assistants	9,443	10,061	70,561	7.01	15
16	Dishwashers	8,632	8,797	53,714	6.11	16
17	Maintenance Workers	2,918	3,011	39,209	13.02	17
18	Housekeepers	8,194	8,592	60,804	7.08	18
19	Laundry	6,283	6,638	50,724	7.64	19
20	Administrator	4,088	4,160	112,383	27.02	20
21	Assistant Administrator					21
22	Other Administrative	1,995	2,159	22,197	10.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: RISK MGR	1,136	1,160	19,271	16.61	32
33	Other(specify) CHAPLIN	2,016	2,080	26,448	12.72	33
34	TOTAL (lines 1 - 33)	152,284	160,318	$ 1,669,473 *	$ 10.41	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,608	L1, C3	35
36	Medical Director	48	6,000	L9, C3	36
37	Medical Records Consultant	48	1,271	L10, C3	37
38	Nurse Consultant	26	1,300	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	42	2,113	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	472	L10A, C3	43
44	Activity Consultant	122	4,887	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	390	$ 20,651		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	121	$ 4,824	L10, C3	50
51	Licensed Practical Nurses	1,386	48,509	L10, C3	51
52	Nurse Aides	1,090	17,438	L10, C3	52
53	TOTAL (lines 50 - 52)	2,597	$ 70,771		53

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULETTE BUCH-MILLER	ADMINISTRATOR	0	$ 65,425
BARBARA RANDOLPH	ADMINISTRATOR	0	46,958
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,383

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CPA FIRM	DATA PROCESSING	$ 29,005
CPA FIRM	AUDIT	3,535
CPA FIRM	COST REPORT & PA AUDIT	3,006
ATTORNEY	CONSULTING	550
VINE STREET CLINIC	PROF CONFERENCE SERV	960
BILL WILSON	COMPUTER CONSULTATIO	2,619
ADVANTAGE MARKETING	BUILDING CONSULTATIONS	4,040
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,715

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,708
Unemployment Compensation Insurance	
FICA Taxes	125,309
Employee Health Insurance	2,898
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
X-MAS & INCIDENTAL	6,184
FLEX PLAN ADMINISTRATION	1,847
CONTINUING EDUCATION	665
TOTAL (agree to Schedule V, line 22, col.8)	$ 189,611

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	171
Health Care Worker Background Check	
(Indicate # of checks performed 40)	521
PUBLIC RELATIONS	4,472
YELLOW PAGES	6,983
DUES- OTHER	828
DUES-ASSOCIATION	6,794
NEWSPAPER & MAGAZINES	1,371
Less: Public Relations Expense	(4,472)
Non-allowable advertising	( )
Yellow page advertising	(6,983)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,685

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHMENT	7,144
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,144

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PLEASANT HILL VILLAGE **#** 0021014 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN 4440; ASSN BRETHREN HOMES 2354**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **GREGORY M. BIERMAN, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE XI. OWNERSHIP COSTS: PAGE 11
FACILITY GROUNDS CONSIST OF 5.58 ACRES
ORIGINALLY THE LAND WAS SECURED BY DONATION IN 1905 BUT DESIGNATED AS HOME SITE IN 1975
AT WHICH TIME IT WAS APPRAISED AT A VALUATION OF $28,5000

SCHEDULE XI OWNERSHIP COSTS: Page 12, 12A, & 12B
IMPROVEMENTS:
SYSTEM DOES NOT DISTINGUISH BY YEAR, ONLY BY ASSET CLASSIFICATION

Facility Name & ID Number PLEASANT HILL VILLAGE # 0021014 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XIX. XUPPORT SCHEDULES -- SECTION G--SCHEDULE OF TRAVEL & SEMINAR

NAME	DATE	LOCATION	TITLE	SPONSOR	REGISTRATION	MEALS	LODGING	TRAVEL	MILEAGE	
MILLER, PAULETTE	7/31/2002	BLOOMINGTC	ADMINISTRATOR	LSN TRUST					49	
ROGERS, PATRICIA	9/30/2002	SPFLD, LFD	DON	SCREENINGS					155	
HAMMANN, J	9/30/2002	SPRINGFIELD	ACTIVITY DIR	ALZHIMERS ASSN					17	
HAMMANN, J	9/30/2002	SPRINGFIELD	ACTIVITY DIR	LSN FOUNDATION					74	
JONES, DAWN	9/30/2002	SPRINGFIELD	DIET SUPER	FOOD SHOW					18	
MILLER, PAULETTE	10/31/2002	PEORIA	ADMINISTRATOR	LSN TRUST					53	
ROGERS, PATRICIA	1/31/2003	CARLINVILLE	DON	SCREENINGS					117	
MILLER, PAULETTE	2/28/2003	OTTAWA	ADMINISTRATOR	LSN TRUST					84	
MILLER, HOLMES DENNISON, ELLER	4/11/2003	CHICAGO	ADMIN, RISK MGR LPN	LSN CONFERENCE		64	731	268		
JONES, DAWN	4/30/2003	BLOOMINGTC	DIET SUPER	FOOD SHOW					53	
MILLER, PAULETTE	5/14/2003	OTTAWA	ADMINISTRATOR	LSN TRUST					83	
ROGERS, PATRICIA	5/16/2003	SPFLD, PEORI	DON	SCREENINGS					125	
MILLER, PAULETTE	5/27/2003	CHICAGO	ADMINISTRATOR	LSN FOUNDATION				224	55	
MILLER, PAULETTE	6/4/2003	LANCASTER I	ADMINISTRATOR	BRETHREN FORUM				810	53	
MILLER, PAULETTE	6/30/2003	GLEN CARBO	ADMINISTRATOR	LSN TRUST					44	
ROGERS, RANDOLPH, KIESLER, DENNISON, ARNOLI	8/29/2002	SPRINGFIELD	DEPT HEADS	LSN FOUNDATION	595					
CPR CLASS - 4 STUDENTS	9/20/2002	PHV	VARIOUS	MELISSA PEIRSON	80					
HOLMES, LENORE	1/25/2003	PHR	RISK MANAGER	LSN FOUNDATION	115					
HOLMES, DENNISON, ELLER	2/28/2003	CHICAGO	RISK MGR, LPNS	LSN FOUNDATION	1,185					
5 EMPLOYEES	2/28/2003	SPRINGFIELL	CERT NURSE ASST	LINCOLNLAND COMM COLLEG	100					
HOLMES, LENORE	2/27/2003	PEORIA	RISK MANAGER	WORKSHOP FEE	75					
MILLER, PAULETTE	3/12/2003	ELGIN	ADMINISTRATOR	BRETHREN FELLOWSHIP					246	
JONES, DAWN	4/15/2003	CARLINVILLE	DIET SUPER	MAC CO PUBLIC HEALTH	95					
BRANDON, MARY BETH	5/1/2003	SPRINGFIELD	LPN	SIU SCHOOL OF MED	50					
WERNER, JEANNETTA	5/6/2003	PHV	CERT NURSE ASST	TIM & MELISSA PIERSON	20					
PORTWOOD, BETHANY	5/6/2003	PHV	DIET ASST	TIM & MELISSA PIERSON	20					
MITCHELL, CHRIS	5/6/2003	PHV	DIET ASST	TIM & MELISSA PIERSON	20					
DUNCAN, DAWN	5/6/2003	PHV	UA	TIM & MELISSA PIERSON	20					
BUT;ER. DEBBIE	5/6/2003	PHV	HOUSEKEEPING	TIM & MELISSA PIERSON	20					
4 EMPLOYEES	5/13/2003	PHV	HEALTHCARE PROV	TIM & MELISSA PIERSON	80					
SHOCKEY, HOWARD	5/20/2003	BRIDGEWATE	CHAPLIN	ANNUAL MEETING			356			
MILLER, PAULETTE	5/27/2003	BALTIMORE	ADMINISTRATOR	CAPTIVE MEETING			167	11		
MILLER, PAULETTE	6/4/2003	PA	ADMINISTRATOR	BRETHREN FORUM		49	610	153		
					2475	113	1864	1466	1226	7144